

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN240AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/06/2009
NAME OF PROVIDER OR SUPPLIER JOHNSON GROUP CARE #1		STREET ADDRESS, CITY, STATE, ZIP CODE 1895 CARVILLE DR RENO, NV 89512		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	<p>Initial Comments</p> <p>Surveyor: 25375 The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p> <p>This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 11/6/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility received the grade of A.</p> <p>The facility is licensed for six Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness. The census at the time of the survey was five. Five resident files were reviewed and two employee files were reviewed. One discharged resident file was reviewed.</p> <p>The following deficiencies were identified:</p>	Y 000		
Y 178 SS=F	<p>449.209(5) Health and Sanitation-Maintain Int/Ext</p> <p>NAC 449.209 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained.</p> <p>This Regulation is not met as evidenced by:</p>	Y 178		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 178	Continued From page 1 Surveyor: 25375 Based on observation and interview on 11/6/09, the facility failed to maintain the interior walls and caulk seal of the bathroom #1, used by 3 of 5 residents (Resident #1, 2 and 5). The tub surround surface had been cut inot and not sealed properly which caused black mold to grow on the sheet rock behind it. There was evidence of black mold along the caulk line where the bathtub met the surround. Severity: 2 Scope: 3	Y 178		
Y 878 SS=D	449.2742(6)(a)(1) Medication / Change order NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order. This Regulation is not met as evidenced by: Surveyor: 25375 Based on record review and interview on 11/6/09, the facility failed to provide evidence that 1 of 5 residents received medications as prescribed (Resident 5). Severity: 2 Scope: 1	Y 878		

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